104 CMR 32.00

DEPARTMENT OF MENTAL HEALTH

COMPLAINT FORM

For Department Use Only

Date Received: ____/__/_____

Received By: _____

Log #: _____

1. NAME OF COMPLAINANT(S) STATUS* ADDRESS AND TELEPHONE # (OR PROGRAM NAME)

a. _____ _____ _____

b. _____ _____ _____

c. _____ _____ _____

2. Client(s)Thought to be Harmed by Matter Complained of (if any and if known) ADDRESS AND TELEPHONE # (OR PROGRAM NAME)

a. _____ _____

b. _____ _____

c. _____ _____

3. NAME(S) OF PERSON(S) COMPLAINED OF (if any and if known) STATUS* ADDRESS AND TELEPHONE # (OR PROGRAM NAME)

_____ _____ _____

_____ _____ _____

c. _____ _____ _____

4. PERSON FILLING OUT FORM (if other than above): _____

_____

5. WHEN DID MATTER COMPLAINED OF OCCUR [Date(s) and Time(s)]? _____

_____

6. WHERE DID MATTER COMPLAINED OF OCCUR? _____

_____

7. Describe what Happened (Continue on back and/or attach additional sheets as necessary): _____

_____

_____

7. What Happened (Continued):

_____

* STATUS: C=Client; E=Employee; H=Human Rights Committee; R=Relative; O=Other (Specify)

_____ Check here if there are any attachments

IF YOU ARE BETWEEN THE AGE OF 18 AND 59 (INCLUSIVE) AND HAVE BEEN SUBJECT TO PHYSICAL OR EMOTIONAL ABUSE YOU CAN CALL THE DISABLED PERSONS PROTECTION COMMISSION 24 HOUR HOTLINE AT (800) 426-9009.

EMPLOYEES OF THE DEPARTMENT OF MENTAL HEALTH AND OF PRIVATE AGENCIES PROVIDING SERVICES TO DISABLED PERSONS WHO HAVE REASON TO BELIEVE A DISABLED PERSON BETWEEN THE AGE OF 18 AND 59 HAS BEEN PHYSICALLY OR EMOTIONALLY ABUSED ARE REQUIRED BY LAW TO IMMEDIATELY REPORT ABUSE TO THE DISABLED PERSONS PROTECTION COMMISSION 24 HOUR HOTLINE AT (800) 426-9009. A WRITTEN REPORT SHOULD BE FILED WITH DPPC WITHIN 48 HOURS OF THE ORAL REPORT.

DATE **COMPLAINANT SIGNATURE**